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Health Care Providers and Influenza Vaccination

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Each winter brings an influenza (flu) season to this country. Health care providers with patient contact are at risk for being exposed to influenza, with the possibility of then transmitting the infection to vulnerable populations if continuing to work while ill. Ongoing transmission among patients and staff may cause an outbreak in a health care facility. Now is the time for facilities to begin developing influenza vaccination plans for next autumn. Recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP) on this topic were published February 9, 2006 by the Centers for Disease Control and Prevention. For the full text see the link below.

Influenza in the Health Care Setting

Washington State has reports of influenza outbreaks every year in nursing home settings, with both patients and staff affected. Nursing homes represent a highly vulnerable population, typically elderly patients with multiple medical conditions. Since the elderly have poorer immunological response to vaccine, it is particularly important that health care providers not introduce nor transmit influenza in these facilities. Hospitals are another health care site with potential for influenza outbreaks and transmission to patients.

Influenza-like illnesses and mild respiratory infections are common among staff working in hospitals or nursing homes. In such settings influenza vaccination of health care providers can prevent illness and mortality among patients, reduce the incidence of outbreaks, and lower employee illness and absenteeism. Investigation of influenza vaccine use among health care providers found coverage is about 40% overall but varies by factors such as level of training, occupational group, and type of facility. Reported barriers to influenza vaccination among health care providers include fear of vaccine side effects, inconvenience, perceived ineffectiveness of the vaccine, and perceived low personal risk for infection.

Influenza Vaccination of Health Care Providers

It is recommended that all health care providers receive annual vaccinations protecting against influenza. An annual dose is needed because immunity wanes and because frequent changes in the circulating influenza strains necessitate changes in the vaccine formulation. When inactivated (injected) vaccine is used the dose is given in the deltoid muscle, ideally by using a needle of sufficient length to penetrate muscle tissue (i.e., needle length >1 inch.) Consult a physician regarding persons known to have anaphylactic hypersensitivity to eggs or to other vaccine components.

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When inactivated influenza vaccine is in short supply, use of live, attenuated influenza vaccine is especially encouraged for eligible health care providers. Concern about the potential for transmitting vaccine virus is based on shedding of vaccine viruses for over two days after vaccination, although transmission of shed vaccine viruses to nonvaccinated persons has been documented only rarely, involving children in a day care center. As a result, live, attenuated influenza vaccine is approved for use only among non-pregnant healthy persons aged 5-49 years not having contact with severely immunocompromised patients (such as requiring a protected environment after hematopoietic stem cell transplantation); such severely immunocompromised patients also should not administer the vaccine and should not have visitors who have received live, attenuated influenza vaccine until seven days after vaccination.

In addition to these restrictions the live attenuated vaccine should not be given to persons with asthma, reactive airways disease or other chronic disorders of the pulmonary or cardiovascular systems; persons with underlying metabolic diseases such as diabetes, renal dysfunction, hemoglobinopathies, or other significant underlying condition; persons with known or suspected immunodeficiency diseases or receiving immunosuppressive therapies; persons with a history of Guillain-Barré syndrome (GBS); or persons with a history of hypersensitivity to eggs or any of the vaccine components. The vaccine is licensed for ages 5 through 49 years.

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Recommendations for Facilities

Facility planning for influenza campaigns should begin as early as February or March with the goal of vaccinating in October and November. Particular efforts should be made in facilities with severely immunocompromised patients. A facility intervention program to increase vaccination rates may include multiple efforts such as publicity and education, reminder recall systems, removing administrative and financial barriers, and monitoring vaccination coverage. For example, using mobile vaccination carts or providing multiple vaccination opportunities can increase staff vaccination.

The Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP) are promoting greater health care provider annual influenza vaccination. They provided the following recommendations for health care facilities:

- Educate health care providers regarding the benefits of influenza vaccination and the potential health consequences of influenza illness for themselves and their patients

- Offer influenza vaccine annually to all eligible health care providers to protect staff, patients, and family members and to decrease health care provider absenteeism.

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• Provide influenza vaccination to health care providers at the work site and at no cost as one component of employee health programs. Use strategies that have been demonstrated to increase influenza vaccine acceptance, including vaccination clinics, mobile carts, vaccination access during all work shifts, and modeling and support by institutional leaders.

• Obtain a signed declination from health care providers who decline influenza vaccination for reasons other than medical contraindications.

• Monitor health care provider influenza vaccination coverage and declination at regular intervals during influenza season and provide feedback of ward-, unit-, and specialty-specific rates to staff and administration.

• Use the level of health care provider influenza vaccination coverage as one measure of a patient safety quality program.

Along with influenza prevention through vaccination, general respiratory hygiene measures can reduce transmission of influenza and other respiratory infections in the health care setting. The same precautions will protect against influenza, other respiratory viruses, and pertussis. The following materials for developing a facility respiratory hygiene campaign are available on the Department of Health website:

Cover Your Cough brochure:	www.doh.wa.gov/Topics/cyc/cyc_bro.pdf
Cover Your Cough poster:	www.doh.wa.gov/Topics/cyc/cyc_smpost.pdf
Cubrase la Boca al Toser poster:	www.doh.wa.gov/Topics/cyc/cyc_sm_sp.pdf

The entire HICPAC/ACIP document with detailed information and references on controlling and preventing influenza in health-care settings is available online:

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr55e209a1.htm